Certificate of Coverage

[UnitedHealthcare Insurance Company]

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [UnitedHealthcare Insurance Company] and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours. The *Group Policy* describes the contractual obligations agreed to between us and the Enrolling Group.

Changes to the Document

Changes to the *Policy* and this *Certificate* must be in writing. We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages. For details, see *Amendments to the Policy* in *Section 8: General Legal Provisions*.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Colorado. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Colorado are the laws that govern the Policy.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the *Office of the Commissioner of Insurance* within the *Department of Regulatory Agencies*.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company]. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Access Plan

We have prepared and maintain a Network access plan that describes how we monitor the Network of providers to ensure that you have access to Network providers. The access plan also has information on the complaint procedures, quality programs and Benefits for *Emergency Health Services*. The Network access plan is maintained at our offices. See the cover of the *Certificate* for our address and telephone number.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to [www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs. This does not apply to Covered Health Services received while coverage is extended during an Inpatient Stay as described in *Section 4: When Coverage Ends* under the heading *Extended Coverage If You Are Hospitalized*.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

[1]*Include when a Per Occurrence Deductible applies.*

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Include when group purchases benefits for acupuncture services.

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.]

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Include when group purchases CHD benefit.

[3.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

Include when group purchases accidental dental benefit.

[4.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).

- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[5.] Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

Include when group purchases durable medical equipment benefit.

[6.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.

- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[7.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided to you at no greater cost than if the services were obtained by a Network provider.

In the case of an Emergency, you may call the 911 emergency telephone access number or its local equivalent. We provide Benefits for Eligible Expenses resulting from the use of emergency telephone access numbers in the case of an Emergency.

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

[8.] Hearing Aids for Adults

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) for adults age 18 and older. Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this Certificate, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

[9.] Hearing Aids for Minor Children

Hearing aids for a minor child, which is a person under the age of 18 years, who has a hearing loss that has been verified by a licensed Physician and by an audiologist are covered. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:

- Initial hearing aids and replacement hearing aids not more frequently than every five years;
- A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
- Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

"Hearing aid" means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. "Hearing aid" shall include any parts or ear molds.

[10.] Home Health Care

Home health care services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, certified nurse aid or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required. Home health services are to be covered when services are necessary as an alternative to hospitalization, or in place of hospitalization. Prior hospitalization is not required.

Home health care visits may be included but are not limited to:

- Skilled nursing visits;
- Home health aide services visits that provide supportive care in the home which are reasonable and necessary to the member's illness or Injury;
- Physical, occupational, or speech therapy that is provided on a per visit basis;
- Medical supplies, Durable Medical Equipment; and
- Infusion therapy medications and supplies and laboratory services as prescribed by a provider to the extent such services would be covered by us had the member remained in the Hospital, rehabilitation or Skilled Nursing Facility.
- "Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purposes of assisting the insured or the family in dealing with a specific medical condition.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six months or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's Physician, a registered nurse, a social worker and a spiritual caregiver.

Benefits are available when hospice services are received from a hospice agency that is licensed and regulated by the Colorado Department of Public Health and Environment.

Hospice services include:

- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse and nursing services delegated to other assistants.
- Bereavement services (limited to a maximum of $1,150 during the 12-month period following death).
- Social services/counseling services.
- Medical direction.
- Volunteer services.
- Drugs and biologicals.
- Prosthesis and orthopedic appliances.
- Oxygen and respiratory supplies.
- Diagnostic testing.
- Rental or purchase of durable equipment.
- Transportation.
- Physician services.
- Nutritional counseling by a nutritionist or dietitian.
- Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- Physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.

Covered hospice services are available in the home on a 24-hour basis during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms. Home is defined as a place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility. Inpatient hospice services

are provided in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the member ("respite care"). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

Include when group purchases benefits for infertility services.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[2]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

[2]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[1]Include for large groups (51+).

[16.] Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility, including services to treat Biologically Based Mental Illness[[1] and Mental Disorders].

Benefits include treatment of Mental Illness whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care.]

One inpatient day is equivalent to:

- Two sessions of Partial Hospitalization/Residential Day Treatment.
- Two sessions of Partial Hospitalization/Day Treatment.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services*.

Special Mental Health Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

[17.] Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this Certificate.

Benefits include:

- Diagnostic evaluations and assessment.

- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional Care.

Include when expanded services for autism are sold.

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Neurobiological Disorders - Autism Spectrum Disorder Services*.]

Include when group purchases benefits for obesity surgery.

[18.] [Obesity Surgery]

[1]Include when specific criteria apply to benefits for obesity surgery and when only the criterion for a BMI of greater than 40 applies.

[Surgical treatment of obesity when provided by or under the direction of a Physician [1]when the Covered Person has a Body Mass Index (BMI) of greater than 40].

[2]Include when specific criteria apply to benefits for obesity surgery and when either criterion must be met.

[[2]Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:]

- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 40.]
- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

Include when group purchases benefits for ostomy supplies.

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[1]*Include when group purchases benefits for infertility services.*

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [[1]Benefits under this section do not include medications for the treatment of infertility.]

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *Prescription Drug List Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

Include when Step Therapy applies.

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.

- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.]]

[3]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[3]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[23.] Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. Benefits include genetic counseling and testing when there is a reasonable probability that, because of family history, parental age, or exposure to an agent which might cause birth defects or cancer in the fetus, the results will affect medical decisions involving the existing Pregnancy. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery. If 48 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.
- 96 hours for the mother and newborn child following a cesarean section delivery. If 96 hours following delivery falls after 8:00 p.m., coverage will continue until 8:00 a.m. the following morning.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefits are provided for well-baby care in the Hospital, including a newborn pediatric visit and newborn hearing screening.

[24.] Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations, including clinical breast examinations and prostate examinations.

- Well baby and well child care.
- Immunizations. Immunization deficient children are not bound by "recommended ages."
- Hearing screening.
- Child Health Supervision Services.

Lab, X-ray or other preventive tests:

- Screening mammography, including:
  - A baseline mammogram for women 35 through 39 years of age.
  - A mammogram every two years for women 40 through 49 years of age.
  - An annual mammogram for women 50 years of age or older.
  - An annual mammogram for women 40 years of age or older who have risk factors, as determined by a Physician.

  Please refer to your Colorado Health Benefit Plan Description Form to determine whether your Benefits are provided on a calendar year or Policy year basis.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening, including:
  - One screening per year for Covered Persons age 50 and over.
  - One screening per year for Covered Persons age 40 and over who are in high risk categories, as determined by a Physician.
- Bone mineral density tests.

[1] *Include when group purchases durable medical equipment benefit.*

[25.] Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Prosthetic arms and legs are based on criteria that will be covered in accordance with Medicare guidelines and criteria[[1] and are not subject to the Durable Medical Equipment Benefit limits]. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are covered in accordance with Medicare guidelines and criteria. Benefits are available for repairs and replacement, except that there are no Benefits for:
  - Repairs due to misuse, malicious damage or gross neglect, and
  - Replacement due to misuse, malicious damage or gross neglect or for lost or stolen prosthetic devices.
- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid

for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[1]Include when group purchases benefits for manipulative treatment.

[27.] Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]

[Short-term outpatient rehabilitation services, are limited to:

- Physical therapy.
- Occupational therapy.

[1]Include when group purchases benefits for manipulative treatment.

- [[1]Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

[3]Include when group purchases benefits for vision therapy.

- [[3]Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

[1]Include when group purchases benefits for manipulative treatment.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [[1]Benefits can be denied or

shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]*Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.*

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]*Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.*

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Include when group purchases plan with SUD benefits. Mandated offer includes benefits for the "treatment of and for conditions arising from alcoholism."

[30.] [Substance Use Disorder Services]

[Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include treatment of Substance Use whether treatment is voluntary on the part of the Covered Person or court ordered as the result of contact with the criminal justice or legal system.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

[The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care.]

One inpatient day is equivalent to:

- Two sessions of Partial Hospitalization/Residential Day Treatment.
- Two sessions of Partial Hospitalization/Day Treatment.

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services*.

Special Substance Use Disorder Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

[31.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Health care services provided at a Network facility, including services provided by a non-Network provider, are to be provided at no greater cost than if the services were obtained by a Network provider.

[2]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases TMJ benefit.

[32.] [Temporomandibular Joint Services]

[Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.]

[33.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Include when group purchases benefits for vision exams.

[36.] [Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases benefit for wigs.

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Colorado Law

[38.] Children's Dental Anesthesia

General anesthesia and associated Hospital and facility charges provided to an Enrolled Dependent child when, in the opinion of the treating dentist, at least one of the following criteria is met:

- The child has a physical, mental or medically compromising condition;
- The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- The child is extremely uncooperative, unmanageable or uncommunicative and has dental needs deemed sufficiently important that the dental care cannot be deferred; or
- The child has sustained extensive orofacial and dental trauma.

[39.] Cleft Lip and Cleft Palate Treatment

The following services when provided by or under the direction of a Physician in connection with cleft lip and/or cleft palate:

- Orthodontic services.
- Oral and facial surgery.
- Habilitative speech therapy.
- Prosthetic devices such as obturators, speech appliances and feeding appliances.
- Otolaryngological services.
- Surgical management.
- Follow-up care by plastic surgeons or oral surgeons.
- Audiological services.

- Prosthodontic services.

If a dental insurance policy is in effect at the time of the birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, no benefits will be provided for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both.

[40.] Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.
- A clinical trial or study approved under the *September 19, 2000, Medicare National Coverage Decision* regarding clinical trials, as amended.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC).*

- *Agency for Healthcare Research and Quality (AHRQ).*
- *Centers for Medicare and Medicaid Services (CMS).*
- *Department of Defense (DOD).*
- *Veterans Administration (VA).*

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Benefits include Covered Health Services provided in accordance with the Covered Person's treating Physician who is providing Covered Health Services after determining that participating in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person and meets all of the following criteria:

- The clinical trial or study is approved under the *September 19, 2000, Medicare National Coverage Decision* regarding clinical trials, as amended.
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner.
- Prior to participation in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, and the general nature and extent of the risks associated with participation in the clinical trial or study.
- The Covered Person suffers from a condition that is disabling, progressive, or life-threatening.

Coverage does not include:

- Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry.
- Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device.
- Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant.
- Cost for the management of research relating to the clinical trial or study.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Covered Person's health plan.

[41.] Colorectal Cancer Screening

Coverage for the early detection of colorectal cancer and adenomatous polyps for those members who are asymptomatic, average risk adults who are 50 years of age or older and members who are at high risk for colorectal cancer, including Covered Persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Network provider.

The following tests are covered as determined by a Network provider that detect adenomatous polyps or colorectal cancer: Modalities that are currently included in an "A recommendation" or a "B recommendation" by the task force.

- "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:
  - Found good evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service substantially outweigh its harms.
- "B recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:
  - Found at least fair evidence that the preventive health care service improves important health outcomes; and
  - Concluded that the benefits of the preventive health care service outweigh its harms.

"Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.

[1]*Include if plan includes a deductible.*

[2]*Insert appropriate Outpatient Surgery cost sharing.*

[[1]The screening for the early detection of colorectal cancer and adenomatous polyps is not subject to any deductibles.] If additional therapeutic or surgical services are required during the screening as a result of screening findings, the Outpatient Surgery [[2][Copayment][,][Coinsurance][and][deductible]] will apply.

[42.] Phenylketonuria (PKU) Testing and Treatment

Testing for phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this Benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of Inherited enzymatic disorders caused by single gene defects.

Coverage for Inherited Enzymatic Disorders caused by single gene defects shall include, but not be limited to the following diagnosed conditions: phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically appropriate, medical foods for home use for which a participating Physician has issued a written, oral or electronic prescription. Benefits for medical foods are described under the *Outpatient Prescription Drug Rider.*

The maximum age to receive this Benefit is 21, except that the maximum age for women who are of child-bearing age is 35.

[43.] Rehabilitation Services - Outpatient Therapy (Congenital Defect and Birth Abnormalities)

Physical, occupational and speech therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

[44.] Telemedicine Services

Covered Health Services received through telemedicine if:

- The Colorado county in which you reside has the technology necessary for the provision of telemedicine; and
- In-person care from a Network provider is not available to you within your geographic area.

Face-to-face contact is not required between you and your provider for services appropriately provided through telemedicine, subject to all terms and conditions of the Policy.

For purposes of this Benefit, "telemedicine" is the delivery of medical services and diagnosis, consultation or treatment using interactive audio, interactive video or interactive data communication. Consultation provided by a provider using telephone or facsimile machine is not telemedicine.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

[1]Remove acupuncture exclusion if group purchases acupuncture benefit.

1. Acupressure [[1]and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for manipulative treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia) except as described under *Children's Dental Anesthesia* and *Cleft Lip and Cleft Palate Treatment* in *Section 1: Covered Health Services*.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- As described under *Children's Dental Anesthesia* in *Section 1: Covered Health Services*.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]

Include when group purchases accidental dental benefit.

3. Dental implants, bone grafts, and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.]
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

Include when the group purchases benefits for speech aid devices and tracheo-esophageal voice devices.

4. Devices and computers to assist in communication and speech [except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if:

- The drug has been approved by the *Food and Drug Administration (FDA)* as an "investigational new drug for treatment use"; or
- If it is a drug classified by the *National Cancer Institute* as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in *FDA* regulations.

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

   This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

Include when group does not purchase benefits for durable medical equipment.

[3.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.
6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*
8. Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
9. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee.
11. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
    - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

    The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Neurobiological Disorders - Autism Spectrum Disorders

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Autism Spectrum Disorder services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
3. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
4. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
5. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*

6. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

7. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.

Delete when benefits are purchased for expanded autism spectrum disorder.

[8.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]

9. Treatment provided in connection with or to comply with involuntary commitments, police detentions, court-ordered treatment and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee.

10. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
    - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
    - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

    The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
    - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[1]Include when group purchases the drug rider.

2 Enteral feedings, even if the sole source of nutrition except for the first 31 days of life. [[1]Benefits for medical foods are described under the *Outpatient Prescription Drug Rider*.]

3. Infant formula and donor breast milk.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters, dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
    - Electric scooters.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Saunas.
    - Stair lifts and stair glides.
    - Strollers.
    - Safety equipment.
    - Treadmills.
    - Vehicle modifications such as van lifts.
    - Video players.
    - Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.

- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

Delete when group purchases optional benefit for weight loss.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

Delete if group purchases benefits for wigs.

[6.] [Wigs regardless of the reason for the hair loss.]

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[M. Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 6 month preexisting condition exclusion to all Covered Persons.

[1.] [[1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 6 months.

This exclusion does not apply to newborn or newly adopted children under the age of 18, or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 90-day period during which the child has not had Continuous Creditable Coverage. Pregnancy is not considered a Preexisting Condition, as indicated in the definition of Preexisting Condition in *Section 9: Defined Terms*.]

[2]This paragraph will be included when group chooses to apply a 6-month preexisting condition exclusion to "timely adds" and an 18-month preexisting condition exclusion to Late Enrollees. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[1.] [[2]Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 6 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn or newly adopted children under the age of 18, or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 90-day period during which the child has not

had Continuous Creditable Coverage. Pregnancy is not considered a Preexisting Condition, as indicated in the definition of Preexisting Condition in *Section 9: Defined Terms.*]

[3]This paragraph will be included when group chooses to apply the preexisting condition exclusion to Late Enrollees only. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[4]Select either 12 or 18 month period.

[1.] [[3]Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [[4]12] [[4]18] months.

This exclusion does not apply to newborn or newly adopted children under the age of 18, or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 90-day period during which the child has not had Continuous Creditable Coverage. Pregnancy is not considered a Preexisting Condition, as indicated in the definition of Preexisting Condition in *Section 9: Defined Terms.*]

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.
5. Speech therapy except:
   - As described under *Rehabilitation Services - Outpatient Therapy* in *Section 1: Covered Health Services;* or
   - Speech therapy as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders; or
   - Therapy for the care and treatment of congenital defect and birth abnormalities for children from age 3 to 6 are covered, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity; or
   - As described under Cleft Lip and Cleft Palate Treatment in *Section 1: Covered Health Services.*
6. Psychosurgery.
7. Sex transformation operations.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.

Include when group purchases rehabilitation services benefits that do not include manipulative treatment.

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

Include unless group purchases optional benefit for TMJ treatment.

[11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

Include when group purchases optional benefit for TMJ treatment.

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.]

[1]Include (and delete #2) when group does not purchase optional benefits for TMJ treatment. [2]Include (and delete #1) when group purchases optional benefit for TMJ treatment.

[12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery[[1],] [[2]and] jaw alignment [[1]and treatment for the temporomandibular joint], except as a treatment of obstructive sleep apnea.

Delete exclusion #12 below if the group purchases benefits for both obesity surgery and weight loss programs.

[1]Include when group does not purchase optional benefit for obesity treatment of any kind. [2]Include when group purchases optional benefit for obesity surgery, but not weight loss programs.[3]Include when group purchases optional benefit for only weight loss programs, but not obesity surgery.

[13.] [[1]Surgical and non-surgical treatment of obesity.] [[2]Non-surgical treatment of obesity.] [[3]Surgical treatment of obesity.]

Include unless group purchases smoking cessation benefits.

[14.] [Stand-alone multi-disciplinary smoking cessation programs.]

Include when group does not purchase optional benefit for Breast Reduction.

[15.] [Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

Include when group purchases optional benefit for Breast Reduction.

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

O. Providers

- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

  This exclusion does not apply to mammography.

[1]Delete exclusion when benefits for infertility treatment are sold. [2]When Benefits for infertility treatment are sold, always delete the exclusion for fetal reduction surgery.

[3]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

P. Reproduction

1. [[1]Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[2]This paragraph will be included only when group purchases Infertility Services benefit. Delete if benefits for Infertility Services are not purchased.

[[2]The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
- Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
- Donor services.]

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[1]Include when group does not purchase infertility benefit.

3. [[1]Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [[3]and voluntary sterilization].

[5.] [[3]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [[3]Contraceptive supplies and services.]

[7.] [[3]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits. This option is available only to groups with 14 or fewer employees.

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

Include the following if group excludes maternity benefits for enrolled dependent children.

[9.] [Maternity related medical services for Enrolled Dependent children.]

Q. Services Provided under another Plan

[1]Include when 24 hour coverage is not sold and delete #4 (24 hour coverage option) below.

1. [[1]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[4]Include when 24 hour coverage is sold and delete option #1 above.

[[4]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

R. Substance Use Disorders

When group purchases SUD coverage, keep exclusions 1-6 and delete exclusion #7. When group does not purchase SUD coverage, keep exclusions 5 (except for the text variable) and 7, delete all remaining exclusions.

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[3.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4.] [Substance Use Disorder Services for the treatment of nicotine or caffeine use.]

[1]Delete when group does not purchase SUD benefits.

[5.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[1], unless authorized by the Mental Health/Substance Use Disorder Designee].]

[6.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include SUD benefits.

[1]Include when the group provides SUD benefits under a separate plan.

[7.] [Services for the treatment of substance use disorder services [[1]that the Enrolling Group has elected to provide through a separate benefit plan].]

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving permanent mechanical or animal organs.

Always include #4 for network only plans. For plans with Network and Non-Network benefits, include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities. Never include exclusion #4 for plans that do not differentiate benefits by network/non-network status.

[4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

T. Travel

Include as standard; delete when product design includes services provided outside the US and its territories.

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]

[2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

Delete exclusion when benefits for vision therapy are provided.

[4.] [Eye exercise or vision therapy.]

[5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

[6.] Bone anchored hearing aids except when either of the following applies:

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

This exclusion does not apply to hearing aids for minor children as described under *Hearing Aids for Minor Children*.

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Delete when Benefits are provided for immunizations for travel.

[2]Delete when Benefits are provided for immunizations for career and employment.

- Required solely for purposes of school, sports or camp [[1], travel,] [[2]career or employment,] insurance, marriage or adoption. This exclusion does not apply to treatments for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding.

[1]Include when plan includes SA benefits. Delete if plan does not include SA benefits.

- Related to judicial or administrative proceedings or orders [except as described under Substance Use Disorder Services [[1]except as described under *Substance Use Disorder Services*].
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.

11. Services and supplies solely for the treatment of intractable pain, including but not limited to services provided by a pain management specialist. For purposes of this exclusion, "pain management" means a pain state in which the cause of the pain cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area.

12. Consultation provided by a provider by telephone or facsimile.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract. Benefits will be paid subject to coordination of benefits with your prior carrier.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must reside within the United States.

Delete when group purchases double coverage.

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

Delete when group purchases double coverage.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents. When you enroll you must submit all enrollment forms and any required payment to the Enrolling Group. The Enrolling Group is responsible for forwarding all enrollment information to us and for making required payments to us.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

[1]Include only if coverage is selected for domestic partners.

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Newborns are covered for the first 31 days of life. If a specific Premium is required to provide coverage for the newborn, you must submit a completed enrollment form to us prior to the expiration of the 31-day period for coverage to continue beyond the first 31 days of life. If no additional Premium is required to provide coverage for the newborn, you are required to submit a completed enrollment form to us prior to the expiration of the 31-day period.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

[1]Include only if coverage is selected for domestic partners.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Permanent legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition. Make corresponding changes related to Late Enrollees in Sections 2 and 9.

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period, Open Enrollment Period, or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date except as described below under *Extended Coverage If You Are Hospitalized.*

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Include if Extended Coverage for Total Disability is included.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

[1]Choose for large groups and delete option [2]. [2]Choose for small groups and delete option [1].

- **The Entire Policy Ends**

  [[1]Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended. See the Notice of Conversion provision in *Section 8: General Legal Provisions*.][[2]If the Policy ends for any reason other than fraud, abuse, or replacement with another group policy, we are responsible for notifying you that:

  - Your coverage has ended; and
  - You may be eligible for an offer of your choice of a conversion basic or standard health benefit plan. See the *Notice of Conversion* provision in *Section 8: General Legal Provisions*.*]*

- **You Are No Longer Eligible**

  Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent." The Subscriber or the Enrolling Group is responsible for providing us written notice to end your coverage.

- **We Receive Notice to End Coverage**

  Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is medically certified as Disabled.
- Depends mainly on the Subscriber or the Subscriber's spouse for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as Disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of Disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be Disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's Disability and dependency within 31 days of our request as described above, coverage for that child will end.

Include when Enrolling Group purchases extended coverage.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.

[1]*Insert applicable number of months.*

- [[1]Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage If You Are Hospitalized

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage would otherwise terminate, coverage will be extended until the date your Inpatient Stay ends. This extension of coverage does not apply if termination occurs due to nonpayment of Premium or fraud. This extended coverage applies only to an Inpatient Stay.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

To qualify for continuation coverage under state law, the Covered Person must meet the criteria below:

- The Covered Person was enrolled, for a period of at least six months immediately prior to termination of coverage, for coverage under the Policy or under any other group plan that was replaced by the Policy that provided benefits similar to benefits under the Policy.
- The Covered Person is not enrolled in Medicare or Medicaid.

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group.
- Reduction in the Subscriber's hours to less than 40 hours a week as a result of economic conditions.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.

Continuation of coverage is subject to the Policy (or a successor policy) remaining in force and the Premium being paid according to the terms of the Policy. If the Covered Person's coverage terminated due to one of the qualifying events listed above, he or she is entitled to continuation coverage under state law.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within 10 days of when coverage ends under the Policy. You must elect continuation coverage within:

- 30 days after the qualifying event, if the plan administrator provides written notice of the right to continue; or
- 60 days after the qualifying event occurs, if the plan administrator does not provide written notice of the right to continue.

You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 18 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is obtained under any other group health plan which does not contain a preexisting limitation or exclusion for any condition which is covered under the Policy.
- The date you become covered by Medicare.
- The date you become covered by Medicaid.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- If the Policy under which you are enrolled is issued to an Enrolling Group that has 50 or fewer employees, you also may apply for conversion coverage without furnishing evidence of insurability if the entire Policy is terminated and not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

[1]Include when Outpatient Prescription Drug Benefits are sold.

The above information should be filed with us at the address on your ID card. [[1]When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Include the name and address of the appropriate Pharmacy Benefit Manager.

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]]

Payment of Benefits

We will pay Benefits within 45 days for paper claims and 30 days for electronic claims after we receive your request for payment that includes all required information.

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[1]Include if pre-service benefit notification includes determining alternate levels of benefits.

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision no later than 30 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting will be conducted within 60 days of receipt of the request for a voluntary second level review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will be notified in writing of the decision within 7 days of completion of the review meeting.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision no later than 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a voluntary second level appeal. Your second level appeal request must be submitted to us within 30 days from receipt of the first level appeal decision. The second level appeal review meeting will be conducted within 60 days of receipt of the request for a voluntary second level review. You will be notified in writing at least 20 days in advance of the date of the review meeting. You will notified in writing of the decision within 7 days of completion of the review meeting.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Voluntary External Review Program

After you exhaust at least one level of the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

You or your representative must file a request for independent external review no later than 60 calendar days after you have received notification of the appeal decision. Your written request for an independent external review must include a completed external review request form specified by the *Office of the Commissioner of Insurance* as well as a signed consent authorizing us to disclose your medical records. New information may be submitted with the request if it is significantly different from the information provided or considered during the internal appeal process.

We will submit a copy of your request to the *Office of the Commissioner of Insurance*, who will select an independent external review entity. The independent external review entity will determine whether to uphold or reverse our appeal decision within 30 working days of receipt of the request for external review. For expedited reviews, the independent external review entity will determine whether to uphold or reverse our appeal decision within 7 working days of receipt of the request for external review.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will

then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Notice of Continuation

In the event of termination of employment, the Enrolling Group will give eligible Subscribers written notice that continuation of coverage under the Enrolling Group's Policy is available. The Enrolling Group will give notice of continuation within 10 days of the date coverage would end. The notice will include the following:

- Notice of the Subscriber's right to continue group coverage.
- The amount of the payments needed to continue coverage.
- Where, when, and how to make payments.

Notice of Conversion

In the event of termination of coverage, a Subscriber who is entitled to make application for conversion coverage will be given written notice of the conversion privilege at least 15 days prior to the expiration of the 31-day conversion period. If the Subscriber is not given notice of his/her conversion rights, the Subscriber will have an additional period with which to make application. This additional period will expire 15 days after the Subscriber has been given the written notice, but in no event will the additional period be continued for more than 60 days after the expiration of the 31-day conversion period established by the Policy. Written notice presented by the Enrolling Group or mailed by the Enrolling Group to the last known address of the Subscriber (as furnished to the Enrolling Group), will constitute the giving of notice for the purpose of this provision. If the Enrolling Group is a small employer group, as defined by Colorado law, we are responsible for providing notice of conversion rights.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years. No statement will be used to void or reduce coverage under the Policy, or be used in defense of a legal action, unless it is contained in a written application.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Covered Persons. [2]Include when rebates are not passed on to Covered Persons.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

[1]Use for small groups (1-50 eligible employees) and delete #2. [2]Use for large groups and delete #1.

- [[1]Riders and Amendments are effective on the Policy renewal date following at least 90 days advance written notice to the Enrolling Group.]
- [[2]Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.]
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund

Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[1]*Include when Benefits are also provided for SUD Services.*

An Alternate Facility may also provide Mental Health Services [[1]or Substance Use Disorder Services] on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Include only when an Annual Maximum Benefit applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Include when benefit for Infertility Services is sold.

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder,* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Biologically Based Mental Illnesses - the following conditions as described in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

Child Health Supervision Services - those preventive services and immunizations required to be provided to dependent children up to age 13 as follows:

- 0 - 12 months: One newborn home visit during the first week of life if the newborn is released from the Hospital less than 48 hours following delivery; six well-child visits; one PKU testing.
- 13 - 35 months: Three well-child visits.
- 3 - 6 years: Four well-child visits.
- 7 - 12 years: Four well-child visits.
- 0 - 12 years: Immunizations. Immunization deficient children are not bound by "recommended ages."

Clinical Trial - an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 90 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.
- The children's basic health plan, established pursuant to Article 8 of Title 25.5, C.R.S.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.

- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any

of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[1]Include bracketed text if group purchases Domestic Partner coverage.

[2]Include bracketed text if group elects to cover a Designated Beneficiary as a Dependent.

Dependent - the Subscriber's legal spouse, Common Law Spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner.] [[2]A Dependent also includes a Designated Beneficiary.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

Include if group chooses to include the parents of the Subscriber as Dependents. [1]Include if group chooses to include the parents of the Subscriber's spouse as Dependents.

[The definition of Dependent also includes parents of the Subscriber [1]or the Subscriber's spouse].]

Modify ages as appropriate to accommodate group decision.

- A Dependent includes an unmarried dependent child under [25 - 30] years of age only if you furnish evidence upon our request satisfactory to us, that:
  - The child is financially dependent upon the Subscriber or the Subscriber's spouse for support and maintenance; or
- A Dependent includes an unmarried dependent child of any age who is or becomes medically certified as Disabled and dependent upon the Subscriber or the Subscriber's spouse.

Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's [25th - 30th] birthday.]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Include when the group does not elect double coverage.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Include the following two definitions if the group elects to cover a Designated Beneficiary as a Dependent.

[**Designated Beneficiary** means a person who has entered into a *Designated Beneficiary Agreement*.]

[**Designated Beneficiary Agreement** means an agreement that is entered into by two people for the purpose of designating each person as the beneficiary of the other person and for the purpose of ensuring that each person has certain rights and financial protections based upon the designation. The right to be designated as a dependent in a health insurance policy must be granted under the Designated Beneficiary Agreement.

A Designated Beneficiary Agreement will be legally recognized if:

- The parties to the Designated Beneficiary Agreement satisfy all of the following criteria:
  - Both are at least 18 years of age;
  - Both are competent to enter into a contract;
  - Neither party is married to another person;
  - Neither party is a party to another Designated Beneficiary Agreement; and

- Both parties enter into the Designated Beneficiary Agreement without force, fraud or duress, and

- The agreement is in substantial compliance with the statutory form that is considered the standard form for the Designated Beneficiary Agreement.

A Designated Beneficiary Agreement is legally sufficient if:

- The wording of the Designated Beneficiary Agreement complies substantially with the standard form;
- The Designated Beneficiary Agreement is properly completed and signed;
- The Designated Beneficiary Agreement is acknowledged; and
- The Designated Beneficiary Agreement is recorded with the county clerk and recorded and recorded in the county in which one of the parties resides. The Designated Beneficiary Agreement will be effective as of the date and time as received for recording by the county clerk and recorder.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Disability or Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation and a Dependent's inability to perform the normal activities of a person of like age and sex.

Include for groups that purchase domestic partner coverage.

[Domestic Partner - a person of the same sex with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

[1]Include if group requires documentation of financial interdependence. If necessary, modify conditions of financial interdependence to support group's requirements.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least [6 - 18] months duration.

- They have joint ownership of a residence.
- They have at least two of the following:
  - A joint ownership of an automobile.
  - A joint checking, bank or investment account.
  - A joint credit account.
  - A lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designates the other as primary beneficiary].

[2]*Include if group requires signed affidavit.*

[[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Please refer to [myuhc.com] for more information.

[1]*Include when U.S. residency is required.*

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [[1]An Eligible Person must reside within the United States.]

Emergency - a sudden and, at the time, unexpected onset of a health condition that a prudent lay person would assume requires immediate attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[1]Include when Benefits are also provided for SUD Services.

Intensive Outpatient Treatment - a structured outpatient Mental Health [[1]or Substance Use Disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

[1]Include when Benefits are also provided for SUD Services.

Intermediate Care - Mental Health [[1]or Substance Use Disorder] treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program which is continuous treatment for at least 3 hours but not more than 12 hours in any 24-hour period.
- Care through an Intensive Outpatient Treatment program.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Include definition of Late Enrollee if it has also been included in Section 2 and Section 3.

[**Late Enrollee** - An Eligible Person and/or Dependent who requests enrollment in a group health benefit plan following the Initial Enrollment Period for which such individual is entitled to enroll under the terms of the health benefit plan, if such Initial Enrollment Period is a period of at least 30 days. An Eligible Person and or Dependent shall not be considered a Late Enrollee if:

- The individual:
  - Was covered under other creditable coverage at the time of the Initial Enrollment Period and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment; and
  - Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a Spouse, legal separation or divorce or employer contributions toward such coverage was terminated; and
  - Requests enrollment within 30 days after termination of the other creditable coverage; or
- The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an Open Enrollment Period;
- A court has ordered that coverage be provided for a Dependent under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of such court order;
- A person becomes a Dependent of a Covered Person through marriage, birth, adoption or placement for adoption and requests enrollment no later than 30 days after becoming such a Dependent. In such case, coverage shall commence on the date the person becomes a Dependent if a request for enrollment is received in a timely fashion before such date; or
- The parent or legal guardian of the Dependent disenrolls the Dependent from the children's basic health plan, established pursuant to *Article 8 of Title 25.5, C.R.S.*, and requests enrollment of the Dependent no later than 90 days after the disenrollment.]

Include when group purchases benefits for manipulative treatment.

[**Manipulative Treatment** -the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit

plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include for large groups (51+).

[**Mental Disorder** - means post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phoebia, agoraphobia with panic disorder, and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient day treatment, and inpatient basis, exclusive of residential treatment. Mental disorders will not be subject to the limitations of Mental Health Services as described above.]

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week and continuous treatment for at least 3 hours but not more than 12 hours in any 24 hour period.

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - *FDA*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, anesthesiologist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Include when benefit for Infertility Services is sold.

[Pre-implantation Genetic Diagnosis (PGD) - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.]

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

[1]Include when all clinicians are considered primary physicians. [2]Include when group purchases SUD coverage. [3]Include when clinicians providing psychological testing are not considered specialists. [4]Delete entire bracketed sentence when all clinicians are considered specialist.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For Mental Health Services [[2]and Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [[3]for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

[1]Include when Benefits are also provided for SUD Services.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services [[1]or Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional

Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Routine Patient Care Costs - all items and services that would be covered if the Covered Person were not involved in either the experimental or the control arms of a clinical trial; except the investigational item or service itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items and services customarily provided by the research sponsors free of charge for any Covered Person in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services; the clinically appropriate monitoring of the effects of the item or service; the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

1Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[1]Include when all clinicians are considered specialists

[2]Include when group purchases SUD coverage.

[3]Include only when clinicians that perform psychological testing are considered specialists.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For Mental Health Services[[2]and Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [[3]For Mental Health Services[[2]and Substance Use Disorder Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Include when group purchases SUD benefits.

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a

disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when Enrolling Group purchases extended coverage and when the corresponding provision has been retained in Section 4.

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

Include for MH (including Neurobiological Disorders) and when group also purchases SUD coverage.

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include for MH (including Neurobiological Disorders) but when group does not purchase SUD coverage.

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
    - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.